FHIMA
Florida Health Information Management Association

e-Coastlines

President's Message

March / April 2002

"Pioneers of the 21st Century - Following the Rhythm of Time"
Mario A. Perez, III, RHIA, CCS, CCS-P

As the year continues to march to the rhythm of time, as pioneers of the 21st century, many symphonies are being orchestrated impacting us in the present and in the future. Never before in the history of our association has its members been inundated with so much information and offered ever changing innovative communication technology to assist us to conquer new frontiers and roles within the health information management profession. There is much stirring in the pot, but as an old Sicilian proverb says, "Only the spoon knows what is stirring in the pot." We have no other choice, but to be involved and informed, if you want to be on the cutting edge of our profession.

This past January, FHIMA held a successful Mid-Year conference, due to the arduous efforts of Peggy Meli, Mid-Year Chairperson and the committee members. Much of subject matter addressed at the conference implied the need for HIM professionals to take the lead in the evolving and metamorphic roles occurring within the spectrum of

the healthcare industry.

FHIMA has taken the lead to ensure our members have a milieu in which to explore new frontiers, opportunities, learn and network. The "Florida Geographic Community", in the AHIMA Community of Practice (CoP) is that milieu and as members you must take every advantage of this opportunity to make the community what you wish it to be. Now every AHIMA member through out the country has the ability to enact through the simple use of this technology. I encourage each of you to log on and explore the CoP and join the Florida Community, the wealth of information you will acquire is priceless! "Technology is like a steamroller. If you are not on the steamroller, then you are destined to become part of the road."

This past August 2001, during the Leadership Conference the major topics of concern addressed were shortages and salaries in the HIM profession. The FHIMA board of directors heard you and AHIMA has just recently commissioned the Center for Health Workforce Studies at the University of Albany, State University of New York to assess these concerns. Please visit the AHIMA web site www.ahima.org for detailed information and see your membership dollars at work.

A major item stirring in the pot is the announcement of the proposed credential in healthcare privacy ("CHP"). The 2001-2002 House of Delegates which is now a year round body is currently in process of reviewing and discussing consideration of this proposal, your FHIMA delegates (Jacquie Jones, Sharol Pasual-Noblejas, Michele Mock, Holly Woemmel and myself) will be electronically voting during the first two weeks in April. Log on to the AHIMA CoP for details on the proposal and post your comments on the Florida Geographic Community, as delegates we will be viewing them and responding to your comments. Your input dictates how your delegates vote.

Soon you shall be receiving the 2002-2003 FHIMA ballot to elect new officers. The Nominating committee chaired by Diane Evangelista, RHIA has done an excellent job in providing a ballot composed of qualified individuals eager to serve you during the next term. The FHIMA Board of Directors extends our gratitude to all nominees accepting to be on the ballot. I encourage you to execute your privilege to vote. As members it is your obligation to do so.

This issue of e-coastlines includes information on the forthcoming FHIMA annual convention to be held June 4 – 7, 2002 in Orlando, FL at the Caribe Royale. The Arrangements and Programs Committee have been feverishly at work composing an innovative agenda and

vendor exhibit. Mark your calendars now and make plans to attend.

Your FHIMA board is always at your service, you have elected us to represent you and administer the association, you the members actually run the association. Your commitment to FHIMA as members is demonstrated in your involvement. I personally look forward to a record breaking voting ballot return, seeing each of you at the convention and joining the Community of Practice.

As members of FHIMA and AHIMA our actions over the course of time, will determine whether our association, as we know it today, will be alive and thrive…or only be a memory.

At the beginning of this message I made an allegoric statement, that many symphonies are being orchestrated impacting us in the present and in the future, in regard to the HIM profession. However, a symphony can only be conducted with a full orchestra. Let us all continue the rhythm of time by being involved.

FHIMA
Florida Health Information Management Association

e-Coastlines

FHIMA News

March / April 2002

FHIMA ANNUAL CONVENTION - 2002
"Pioneers of the 21st Century - Following the Rhythms of Time"
Judy Gygi, RHIA
Arrangements Chairperson

Date: June 4-7,2002

Place:
Caribe Royale Resort Suites & Villas
8101 World Center Drive
Orlando, FL 32821
407-238-8000 or 1-800-823-8300

Tuesday, June 4, 2002	**(TENTATIVE SCHEDULE) 15 CEU's OFFERED**

Registration Hours	**11:00 AM – 1:00 PM**
Hospitality Hours	**CLOSED**
Exhibit Hours	**CLOSED**
11:00 AM – 1:00 PM	**Registration**
1:00 PM – 5:00 PM	**House of Delegates** *All members are encouraged to observe the FHIMA Legislative process*
6:00 PM – 8:30 PM	**Leadership Dinner** (By Invitation Only)
Wednesday, June 5 2002	
Registration Hours	**7:00 AM – 11:00 AM**
Hospitality Hours	**10:00 AM - 4:00 PM**
Exhibit Hours	**10:00 AM - 4:00 PM**
8:30 AM - 10:30 AM	***Keynote Speaker "Selling Yourself"*** *Margaret Stewart, RHIA* A dynamic speaker with great advice for selling yourself in the marketplace. (Management Development - 2 CEUs)
10:30 AM - 11:00 AM	**Break**
11:00 AM - 12:00 PM	**Legislative Update** *Bill Bell, JD* A review of proposed state legislation that may impact HIM. (External Forces– 1 CEU)
12:00 PM - 2:00 PM	**Membership Luncheon**
2:00 PM - 3:00 PM	**The "Nuts and Bolts" of Remote Coding** *Mary Agnes Fields-Hinkle, RHIT* A view on the technical aspects of Remote Coding. (Technology – 1 CEU)
3:00 PM - 3:30 PM	**Break**
3:30 PM - 4:30 PM	**Communities of Practice** *Lori Eytel Lucas, RHIA* Hear about the advances on the latest on-line initiative offered by AHIMA with a live demonstration.

	(Technology – 1 CEU)
Thursday, June 6, 2002	
Registration Hours	**7:00 AM – 11:00 AM**
Hospitality Hours	**10:00 AM - 3:00 PM**
Exhibit Hours	**10:00 AM - 3:00 PM**
8:30 AM - 10:30 AM	**"Copying Costs - What's it worth - Under HIPAA?"** *Rose Dunn, RHIA* Analysis of the privacy regulations and the costing methologies (External Forces – 2 CEU)
10:30 AM - 11:00 AM	**Break**
11:00 AM - 12:00 PM	**AHIMA Advocacy & Update Policy** *Don Asmonga, MBA* (External Forces – 1 CEU)
12:00 PM - 2:00 PM	**LUNCH WITH THE EXHIBITORS**
2:00 PM - 3:00 PM	**HR Issues/Topics** *Debbi Ruthenbeck* (Management Development – 1 CEU)
3:00 PM - 3:15 PM	**Break**
3:15 PM - 5:15 PM	**"Alternate and Emerging HIM Careers"** *Panel Discussion* Exploring careers in the areas of Compliance/HIPAA Officer, Risk Manager, Transcription, Consultant, Hospice, Long Term Care, Mental Health & Radiology Billing. (Management Development - 2 CEU)
Friday, June 7, 2002	
Registration Hours	**7:00 AM – 11:00 AM**
Hospitality Hours	**CLOSED**
Exhibit Hours	**CLOSED**
8:30 AM - 9:30 AM	**AHIMA Update** *Katherine Byrd, RHIA* A lively update on the latest issues of AHIMA. A presentation on clinical aspects of

	Cardiology. (Management Development – 1 CEU)
9:30 AM - 10:00 AM	**Break**
10:00 AM - 12:00 PM	**Current Coding Issues affecting HIM** Barbara Flynn, RHIA, CCS A physician's perspective on the Electronic Patient Record. (Clinical Data Management - 2 CEU)

Registration Fee Structure:

Registration Type	FHIMA MEMBER Advance (by May 2, 2002	FHIMA MEMBER Late	NON-MEMBER Advance (by May 2, 2002	NON-MEMBER Late
FULL (6/4-6/7) includes ALL food functions	$225	$250	$250	$275
Wednesday Only (6/5) includes Membership Luncheon	$135	$150	$150	$165
Thursday Only (6/6) includes Exhibitor Lunch	$135	$150	$150	$165
Friday Only (6/7)	$100	$115	$115	$130
* Student - includes ALL food functions	$90	$100 Daily $35		
* Student - does NOT include food functions * Students **MUST** pre-register by May 15, 2002 to qualify for free registration.	$0	$30 Daily $30		

* HIM students - to qualify for the discounts, you **MUST** be an AHIMA member, a member of FHIMA **AND** have your Program Director sign the registration form.

To register on-line with a credit card OR for a complete registration form, CLICK HERE.

Attire: Business Casual

For exhibit space, contact Lori Eytel Lucas, RHIA at fhima@infi.net or (941) 597-1751.

CARIBE ROYALE RESORT SUITES & VILLAS

The "Perfect Place". A plush, regal oasis in Central Florida ideal for business, pleasure or a little of both, the Caribe Royale offers the best of all worlds. Three beautifully statuesque towers, all with spacious two-room suites, are each designed with the purpose of your trip in mind. For Pleasure, Business or Family Vacation the "Caribe" has blended lush landscaping, cascading waterfalls and a calypso of amenities for you...creating its own tropical rendition of classic hospitality, for you and your family to enjoy while on vacation in the Disney Area of Orlando, Florida.

Rates:
Single/Double - $135
Standard King - $135
King Deluxe - $155
Executive Suite - $235
Villas - $235

Reservation Phone Number:
1-800-823-8300

Reservations must be received **no later than May 4, 2002**. Reservations must be guaranteed by advance payment of one night's rate.

Resort Activities:

- Thrill-seekers prepare for a rush of adrenaline as you careen down the 75-foot waterslide past the cascading waterfalls into the resort's fabulous heated swimming pool.
- The kids can explore the Children's Wading Pool with interactive water toys and fully equipped children's playground.

- Work out in your choice of two state-of-the art exercise facilities or serve up a set of tennis on one of the resort's newly surfaced, night-lighted tennis courts.

More Resort Perks…

- Free Parking
- Free Transportation to Theme Parks
- Luxurious Hotel Setting
- Breakfast Included with Room Rate
- Great Water Slide for Kids

Watch for the complete registration and convention information in the March/April issue of e-Coastlines.

For more information contact:
Lori Eytel Lucas, RHIA at (941) 597-1751

2002 FHIMA BALLOT
President Elect **(Vote for One)** [] Ashlyn Dellenger, RHIA Orlando - Central [] Lois Yoder, RHIT, CCS Naples - Southwest
Director **(Vote for Three)** [] Claudia Keating, MEd, RHIA Port St. Lucie - Suncoast [] Elizabeth Kelly, RHIA Cape Coral - Southwest [] Tanya Richey Kuehnast, MA, RHIA Melbourne - Central [] Daniel Land, RHIT, CCS Lakeland - Central [] Michelle Mock, MSM, RHIA Tampa - Gulfcoast [] Jan Morat, RHIA Miami - South Florida [] Gladys Worlds, MS, RHIA Tampa - Gulfcoast
Delegate to AHIMA **(Vote for One)**

[] Gwen Anderson, RHIT
Fort Myers - Southwest
[] Silvia Ortiz, RHIT, CMSC
Miami - South Florida
[] Julie Shay, RHIA
Gainesville - Central
[] Linda Stone, RHIT
Orlando - Central

AHIMA Nominating Committee (Vote for One)

[] Jacquie Jones, MBS, RHIA, CPHQ
Orlando - Ocean
[] Judy Smith, RHIA
Melbourne - Central

Exercise your privilege to vote and return your ballot **no later than April 26, 2002**.

Are you ready for HIPAA?
Geri A. Evans
Vice President/Public Relations
Florida Hospital Association

Are You Ready for HIPAA? Do You Know Which State Laws are Preempted? One of the greatest concerns by providers and payers about being in full compliance with HIPAA regulations by next year , is identifying all state laws potentially subject to preemption and then determining to what extent the laws are, in fact, preempted by the HIPAA medical privacy regulations. Each law must be reviewed on a provision-by-provision basis - an extraordinarily time-consuming and arduous task. The good news is that there is a comprehensive reference manual ready to be released that will remove any worry about this portion of compliance.

Florida Hospital Association Management Corporation's soon-to-be released manual titled, Florida HIPAA Preemption Analysis: A Comprehensive Review of the Florida Statutes, is what you need to move forward with compliance. The 3-ring binder is indexed, tabbed, and ready to guide you through an analysis of your existing medical privacy policies and procedures. In clear language, the reference manual de-mystifies the Florida statutes relating to medical privacy while offering you an incredible savings of time and money. It covers provisions applicable to hospitals, physicians, other independent practioners, post-acute care providers, and payers.

The document, prepared by FHAMC staff in conjunction with members of the Florida Academy of Healthcare Attorneys and Florida Healthcare Corporate Compliance Association, will be available mid-March; however, an order form is available on the Florida Hospital Association's Web site, www.fha.org. Updates will be made available as the regulations continue to unfold. Place your order today. If you have any questions, please contact Kathy Reep, FHA VP/Financial Services at 407/841-6230 or kathyr@fha.org.

FHIMA Annual Convention 2003

Mark your calendar - do not miss the FHIMA Annual Convention July 14-17, 2003 at the beautiful Gaylord Palms Resort, Orlando, Florida.

Mid-Year 2002

Kudos to Peggy Meli, RHIA, Mid-Year Chairperson and her committee for a great Mid-Year. Special thanks to the following vendors for their support at Mid-Year:

- Automated Document Solutions
- Digital Voice Systems
- Executive Record Services
- FYI Healthserve
- In Record Time
- Lexicode
- MedQuist
- Woodham & Associates

2002 FHIMA SCHOLARSHIP
Sharon Fitzgerald, RHIT

Florida **H**ealth **I**nformation **M**anagement **A**ssociation is pleased to announce a continued support of individuals pursuing Health Information Management

careers. FHIMA has again voted to provide scholarships this year to students enrolled in both undergraduate and graduate studies related to the Health Information Management field.

As in years past, scholarships will be awarded to FHIMA members to defray the cost of a Health Information Management related education. Awards will be presented at the Membership Luncheon during the 2002 Annual Convention. Scholarship recipients will be notified in writing of their award in May. Scholarship recipients are strongly encouraged to be present at the Annual Convention Membership Luncheon to accept the award.

APPLICATION INFORMATION:

Applications are available from Program Directors, on the FHIMA website, or by contacting the Scholarship Chairperson. Your completed scholarship application and required attachments must be received by the FHIMA Scholarship Chairperson no later than published deadline.

Eligibility Requirements:
Applicants must be presently enrolled in one of the following program

Health Information Management Program.

Health Information Technology Program.

Graduate level degree seeking program relevant to H.I.M. (Graduate applicants must be either an RHIA or RHIT and have a bachelor's degree)

Current membership in AHIMA/FHIMA .

An individual is only eligible to win one scholarship for each category.

APPLICATION DEADLINE: March 31, 2002

Mail Applications & Attachments To:
Sharon Fitzgerald, RHIT
FHIMA Scholarship Chairman - 2002
809 SW 6th Court, Cape Coral, FL 33991-2458
(H) 941-458-4658
(W) 941-851-0474
sharonart422@yahoo.com

SCHOLARSHIP SELECTION:

FHIMA utilizes a point system to evaluate scholarship applicants. Scholarship Committee members will review the applications for the following criteria:


Properly completed application -- with attachments present


Scholastic ability -- official transcripts will be reviewed


Leadership ability -- the resume and/or other documents will be reviewed. The following areas will be considered: awards/honors, previous and current employment (if any), school activities, volunteer work etc…


Potential contribution to the profession -- the essay titled "How I Plan to Achieve My Long Range Professional/Career Goals" (undergraduates) or career objectives (graduate) will be reviewed.


Professionalism – supporting letters and professional organization membership

Click Here For The FHIMA Scholarship Application AND Reference Criteria Form.

Articles

March / April 2002

MY TURN – AN EDITORIAL COMMENT

WHAT IS A CODER? PART 2.

Barbara D. Bernstein, RHIA, CCS
Coding Consultant
Florida Hospital Association

First, I would like to thank you for the positive response my article received. Since then I have had the opportunity to talk to more of my fellow coders, hear their stories, and participate in a few more frustrating experiences. Last time I focused on how people don't even know what a coder is or what we do. This time, I want to address the necessity for correct coding. Even people, who understand that codes are necessary for billing and reimbursement, don't fully understand the importance of correct coding. The following situations serve to underscore that problem.

I recently sat in on a meeting of Emergency Room coders who were working on revenue issues. The person in charge of this project was a nurse with no coding knowledge. The lady in charge of the assembly and analysis of ER charts was also a nurse with no coding

knowledge. We were discussing coding of certain procedures and the codes used for them. Those of you who use the 3M system know that the ICD-9 procedure codes will automatically crosswalk to the CPT codes. However, there was one particular code in ICD-9 that did not crosswalk to the correct CPT code that the coders were supposed to use. The project nurse asked why couldn't the coders just enter the necessary codes. I very politely asked if I could speak freely. I then explained that the coders need to know how to get to a code. This is not just for their personal knowledge, but to make sure the correct codes are assigned, and to train new coders. Otherwise, we would just be data entry people who would enter or accept any code, whether it was correct or not. The coding educator thought I handled this very professionally, even though it did make me want to bang my head against the wall. Once again, even health care professionals thought coders just pulled a number out of a book (or thin air) and placed it on a chart.

The second instance happened to a coder friend of mine. She went to her doctor for palpitations. The superbill didn't have a code for palpitations, so he circled arrhythmia. The code for arrhythmia happened to be next to the code for CAD and, you guessed it, the bill was submitted with coronary artery disease as the diagnosis. She is now fighting to get her record corrected. The sad part is that the office worker in the doctor's office doesn't understand what the big deal is.

I think we have two issues here, experience and education. The ER project is a perfect example of lack of experience. While the nurses brought a wealth of clinical experience to the project, they had no knowledge of or experience with coding. They just wanted to pick a code and go on to the next procedure. Experienced coders should be in charge of coding issues in the ER (or any other department for that matter.) This is the only way to ensure that charts are coded correctly and that coding practices are compliant with regulatory and billing guidelines. Does this mean that nurses can't be in charge of coding issues? That's a discussion for a different article. Whoever is in charge of coding issues for a department should know what coding is and what is involved with selecting the proper codes. No amount of training can substitute for hands on experience in coding.

Once again, this brings us to the question of educating people about coding. How do we educate the physician and his office staff about the importance of correct coding? How do we explain the consequences of incorrect coding? One hospital I recently visited is going to start by putting little notes on physicians' charts waiting for dictation or signatures. The notes would ask for simple things, like documenting diabetes as type I or type II, (instead of just

documenting diabetes.) They are also considering hosting lunch and learn sessions for physicians to educate them on coding issues. This type of training could be extended to other areas in your facility as well.

Physicians' offices are another matter. You may have to start by explaining to your personal physician's billing clerk why it's a bad thing to have CAD documented on your chart instead of palpitations. Explain why this isn't just a little mistake and what the consequences are. You could suggest that symptom codes be added to his superbill to prevent patients from being labeled with diseases they don't have.

These are just a few ideas. Let's put our heads together and try to figure out a way to educate people about the importance of coding and coding correctly. If you or your facility has come up with a good idea for education, please share it with us. I hope to hear from you. My email address is *bdbernstein17@aol.com*.

Medical Necessity
Cheryl Bowling, RHIT, CCS
Kforce, Inc.

By now most of you have heard something about medical necessity. Possibly you have had a chart returned (inpatient or outpatient), MRI report or mammography report, lab codes or other outpatient encounters with the comment "This does not meet medical necessity". Let's take a brief look at what medical necessity means to Medicare and third-party payers.

Medicare defines "medical necessity" as a determination of a service that is reasonable and necessary for the diagnosis or treatment of illness or injury. Most third-party payers abide by this definition but many use their own interpretation of medical necessity. Each insurance company (commercial, Medicaid or Medicare) may determine by the CPT code assigned which diagnoses codes will justify medical necessity. Also, medical necessity is established by the use of ICD-9 diagnosis codes. Local medical review policies (LMRP) will define what ICD-9 codes support the medical necessity for many services.

Medical necessity has many factors that determine if a service meets criteria. These include covered services,

non-covered services, LMRPs, and specific ICD-9 diagnostic codes to name a few. Specifics for medical necessity are typically located in administrative manuals, policy manuals, Internet sites and Medicare billing manuals. An example of medical necessity is the patient who decides that he may be at risk for prostate cancer and asks his physician for a PSA test while visiting the physician's office for an upper respiratory infection. The test is completed and coded with the URI code for which the patient came to the office. Medical necessity is not established and the claim is rejected.

This is a very brief overview of medical necessity but hopefully will give you some insight the next time you hear, "This case does not meet medical necessity." We in HIM positions can make a definite difference when reviewing and coding encounters/charts/ visits. Be aware that some aids to fend off rejections due to medical necessity issues are: medical necessity software packages, ensuring that trained personnel only assign the CPT and ICD-9 codes, make sure you are up to date regarding compliance issues, LMRPs, third-party payer manuals and HIM input in designing patient test requisition forms.

Notes:

1. Gregg, Cheryl & Sherri Mallett. "Who Answers the Medical Necessity Question?" Journal of AHIMA, June 2000.
2. CMS, Medicare Policy Manual.
3. Rosenfeld, Stephen & McGorrian, Clare. "Medical Necessity: The Gateway to Meaningful Health Care Access"

Coding Compliance
Karla Philippou, RHIT, CCS, CCS-P, CPC

Coding issues continue to plague our hospitals. Having certified coding professionals does not guarantee quality and accuracy. Ambiguity abounds and many resources contain conflicting information making it difficult or impossible for coders to be certain they are correct. In fiscal year 2000, the payment error rate was estimated at $11.9 billion. More than ever it is imperative that hospitals track coding accuracy and consistency of thei coders. 100% accuracy is probably not attainable because there will always be issues contained within the clinical recc that are open to interpretation, but by having a coding

compliance plan in place consistency within an organization should be possible.

Putting a coding compliance plan in place and using it to monitor results should improve your facility's bottom line. What steps can be taken to help improve coding accuracy a consistency?

Review coding policies and procedures to ensure they are current. If a facility doesn't have policies and procedures for coding, now is the time to adopt them. A good starting point is the "Official ICD-9-CM Guidelines for Coding and Reporting." These can be found online at: www.cdc.gov/nchs/data/icdguide.pdf. Make sure the coding staff is familiar with these coding guidelines and the facility's coding policies and procedures. Make certain the policies contain specific steps to follow when there are problem charts. The key is consistency among the coding staff. If similar scenarios are coded consistently and are covered in the coding guidelines, there is less likelihood of fraud. Policies and procedures should be updated regularly and minimally at least once a year.

Keep all the coding resources up to date. In addition to current ICD-9-CM, CPT-4, and HCPCS Level II books, facilities should have subscriptions to Coding Clinic and CPT Assistant. The American Hospital Association also has a new publication called, "Coding Clinic for HCPCS," to help facilities stay abreast of changes in APC regulations and reporting. Current drug books, book of abbreviations, anatomy and physiology, as well as The Merck Manual are essential tools. If you have multiple sites or facilities, a minimum of one copy should be available at each site where coders are working.

Audit all coders regularly, for consistent and correct coding. Although, the audit may be used as part of the performance review for the coders, results should not be punitive. Audits should be done for each coder at least quarterly; however, a monthly review should be done when initiating an audit process to identify problem areas. A policy should spell out the expected accuracy rate for coders. Remember not to make the standard too high. Consequences for not achieving the standard should be clearly stated in the policy. Coder education should be one of the primary goals of the audit. Procedures routinely performed in your facility should be included in the audit.

Open communication is imperative. Staff meetings should be held regularly at scheduled intervals. If the coders specialize in the type of coding they perform, i.e. inpatient, outpatient, or ER, some meetings should be held with specific coding specialties to address problems that are specific to that subset. General results of audits and specific problems identified should be addressed. Coding

staff should be made aware of reimbursement issues that may be affected. One example might be when a specific diagnosis may be required in order for the facility to be reimbursed for the service/procedure performed. If the coding staff is made aware of this requirement, they will be able to search for appropriate documentation within the chart. Make sure these meetings are well documented to cover compliance issues: agenda, attendance, any resultant changes in policy or procedure, and dates. Make sure anyone not present receives copies of minutes and any changes made. Staff meetings are excellent opportunities to discuss results of audits and correct any errors identified.

Most importantly, it is essential to provide ample educational opportunities for all coding staff. Maintain logs of educational seminars, workshops, and in-services provided and make sure all staff has equal opportunity to attend. Ideally, the facility should not only pay for the workshop but the time should be part of the employees' workday and not have to be "made up." Coding supervisors should support membership in local HIM organizations and activities and encourage membership in these organizations. By permitting staff to attend such events, the facility can remain abreast of upcoming and current changes in healthcare coding and reimbursement. By keeping the lines of communication open and allowing our coding professionals to share in responsibility for facility compliance, coders are more likely to respond to the facility need for quality and accuracy. Coders are professionals who should be supported in their profession. Keeping coders educated is part of a good compliance plan and benefits the facility in the long run.

FMQAI, the Florida Peer Review Organization has added an e-Learning center to their website which allows coders to earn free continuing education units by completing the online course about the Payment Error Prevention Program. To do this, go to www.fmqai.com and click on e-Learning center and follow the prompts. The internet is just one of the valuable resources available to coders to help keep in step.

Security According to HIPAA
Sharon Henderson
Orlando Regional Healthcare

Don't wait until HIPAA's Security Regulations are finalized to start evaluating your current state of security. With the implementation of the Health Insurance Portability and Accountability Act (HIPAA), health care is faced with the huge task of assessing risk, evaluating processes, and documenting compliance regarding the privacy and security of health information. The proposed security requirements for HIPAA are simply information security best practices from other industries. They are long overdue as the standards that health care should also be required to adhere to.

While the Security Rule does not require that health care facilities implement specific new technologies, HIPAA does require us to take a closer look at our processes and procedures regarding the protection of health information and to determine whether it is time to make some changes regarding security. For example, the administrative procedures require, among other things, information access control. This includes access authorization, access establishment, and access modification. A perfect solution to this, as well as the access control requirements included in the technical security services, might be an enterprise-wide security administration system. This system would allow user access to be controlled through a job code matrix managed by Human Resources. Managers would submit requests for new employees to fill a specific position level. The position level would already have required system access setup in the job code matrix. Access would be generated automatically with the hiring process. If an individual's job level changed, then the system would automatically change their level of access to coincide. Subsequently, when an individual separated from the organization, their access would all be immediately removed.

HIPAA requires that we take a very close look at the level of authentication that our systems require when health information is being stored. What is the corporate culture like in your facility? Most information systems in use today provide for unique user IDs and password protection at a minimum. Does your system require that there be a minimum of 8 characters in a password? Does it contain a password dictionary that will disable the use of many easily guessed passwords? Does it maintain a password history to ensure that a password is not reused? Do your users routinely choose passwords that are difficult to guess? The use of unique user IDs and passwords can be

an effective means of authenticating a user to a system, but if the proper protections are not in place, then passwords can be an easily-bypassed entrance to a system.

Now is a good time to evaluate whether the use of biometric or token-based authentication would be best. Biometric devices have evolved technologically in the last three years. Token-based authentication, e.g. the use of smart card technology, can be expensive to implement, but is a very effective means of authentication that can be difficult to circumvent.

Because the Security Rule has not yet been finalized, the HIPAA security requirements may change. Even if they do, health care would greatly benefit by using the reasonable standards set by the proposed rule. It can serve as a checklist of security measures to be incorporated into our everyday practices. The examples mentioned previously are only the tip of the Security iceberg. Take advantage of the Security Rule's delay and evaluate your security now to see how it measures up to the standards as they are written.

Sharon has recently accepted the challenge of developing and implementing HIPAA Training for Orlando Regional Healthcare. Prior to this she served as Security Manager for ORH.

Anthrax Coding Notes
***C**hristina Brown, RHIA, CCS*
Chief Compliance Officer
Kforce, Inc.

Reprinted courtesy of the: AHIMA CoP for Society of Clinical Coding.

According to Sue Prophet, RHIA, CCS, Director of Coding Policy and Compliance for AHIMA, there was some discussion of Anthrax coding practices at the recent ICD-9-CM Coordination and Maintenance Committee meeting in Baltimore. Per the discussion at the C&M meeting, if the patient has actually been exposed to anthrax or has come in contact with anthrax spores, code V01.8 should be assigned. If the person has a concern that he has been exposed and seeks evaluation but is found not to have been exposed and not have anthrax, code V71.89 should be assigned. It is important to note

that V71.89 can only be assigned if the results of the test are known to be negative. If it is unknown what the test results are, then V71.89 cannot be assigned. It was suggested that for a patient who thinks he may have been exposed (but the exposure is not known for sure) and the test results are unknown, code V01.8 should be assigned. Asymptomatic patients who test positive by nasal swab should be coded to 795.31.

Only confirmed cases of Anthrax are assigned the ICD-9-CM code from the 022 category. The appropriate fourth digit is assigned for the specific type of Anthrax identified.

Another question that is bound to come up involves a patient who is just anxious-no reason to think he may have been exposed, but he just wants to be tested (the "worried well"). V65.5 is probably a good choice for these patients.

At the present time, the E Code recommended for a confirmed exposure to Anthrax is E968.8 (Assault by other specified means). Code E997.1 (Injury due to war operations by nuclear weapons, biological warfare) is reserved for military operations not individual terrorist acts. The National Center for Health Statistics is considering the creation of additional E Codes for terrorism to meet the data collection requirements of the future.

FHIMA
Florida Health Information Management Association

e-Coastlines

AHIMA Update

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EMR UPDATE

According to a recent survey from the Medical Group Management Association Center for Research, 21.6 percent of healthcare organizations have implemented an EMR (electronic medical record) system and 67.9 percent are considering it. Those who successfully implemented an EMR system did so by seeking coordinated involvement from staff, leadership, and the provider. The creation of a pre-installation plan coupled with vendor-provided on-site training were additional keys to success. Some organizations, however, reported barriers to success. The include lack of financial resources for implementation, difficulty integrating systems, and lack of provider support.

Preventive Care Tool
The Agency for Healthcare Research and Quality (AHRQ) announced the availability of the new Prevention Quality Indicators, a free tool for detecting potentially avoidable hospital admissions for certain illnesses that can be effectively treated in the outpatient setting. To download the software, go to www.ahrq.gov/data/hcup/prevqi.html

JCAHO
The Joint Commission on Accreditation of Healthcare Organizations announced a new option to assist long-term

care organizations reduce duplicative data collection requirements associated with the ORYX initiative. The plan provides for the creation of an Internet-based reporting system that will allow long-term care organizations to self report to the JCAHO the aggregate quality indicator data from the Minimum Data Set mandated by the Centers for Medicare and Medicaid services.

HIPAA

The US Senate accepted the HIPAA compliance language on December 12, 2001, that was previously passed by the US House of Representatives. This legislation provides conditions to receive a one-year extension of the October 16, 2002, compliance date for the HIPAA transactions and code sets final rule. It was signed by President George W. Bush on December 27, 2001. The language establishes conditions for covered entities to receive a delay, provided those entities submit a compliance plan to the Secretary of Health and Human Services by October 16, 2002. Failure to submit a plan or be in compliance by October 16, 2002, can result in an entities' participation in the Medicare plan.

Medicare Beneficiary Database

The Centers for Medicare and Medicaid Services recently announced plans for a Medicare Beneficiary Database (MBD). The database is expected to contain a beneficiary insurance profile to "provide a database of pertinent and comprehensive personal data on people with Medicare and persons dually eligible for both Medicare and Medicaid under either Fee for Service of Managed Care Programs." The data in the MDB will be at the personal level and identified through an individual health insurance claim number. For more information, go to www.access.gpo.gov/su_docs/fedreg/a011206c.html

Contacting AHIMA

For general queries, email info@ahima.org. For professional practice questions, go to the AHIMA Online practice forums at http://www.ahima.org/bibs/index.html or send email to: proprac@ahima.org.

If you'd like to update your mailing address or email address, include your full name, member ID number and your new information - send to: info@ahima.org. For general questions, contact AHIMA Online.